CONFIDENTIAL PRE-NATAL APPLICATION FOR ENROLLMENT

333 Buchner Place, La Crosse, WI 54603 608-785-2070

THIS APPLICATION SHOULD ONLY BE FILLED OUT AND SIGNED BY THE PRE-NATAL PARENT

1

MOTHER'S NAME:____
FIRST, MIDDLE, LAST

DATE OF BIRTH: ______________________________

RACIAL/ETHNIC BACKGROUND (Check **ALL** that apply): ☐ **White** ☐ **Black/African American** ☐ **Asian** ☐ **American Indian/Alaska Native** ☐ **Native Hawaiian/Other Pacific Islander** ☐ **Other:** ____________ **Hispanic/Latino? (Y / N)**

PRIMARY LANGUAGE: ☐ **English** ☐ **Spanish** ☐ **American Sign Language** ☐ **Other:** ____________

ENGLISH SPEAKING ABILITY: ☐ **Very Well** ☐ **Well** ☐ **Not Well** ☐ **Not At All**

PRIMARY PHONE: ____________________**(H/C/W) OPT in for text messages (Y / N)**

SECONDARY PHONE: ____________________**(H/C/W) E-MAIL ADDRESS:** ____________________

EDUCATION: (please write highest grade completed) ____________

WORK HISTORY: Are you working? (Y / N) ☐ Part Time ☐ Full Time (35 hr +) ☐ Other ____________

2

WHAT TRIMESTER OF PREGNANCY ARE YOU IN: ☐ **1ST** ☐ **2ND** ☐ **3RD**

DUE DATE: ____________ **NUMBER OF PAST PREGNANCIES** ____________**(DO NOT COUNT CURRENT PREGNANCY)**

NUMBER OF LIVE BIRTHS: ____________

ARE YOU RECEIVING PRENATAL CARE: ☐ **Yes** ☐ **No**

DO YOU OR YOUR DOCTOR HAVE ANY CONCERNS WITH YOUR PREGNANCY: ☐ **Yes** ☐ **No**

IF YES, PLEASE COMMENT BRIEFLY: ____

3

HOME ADDRESS: ____
(Street address) (Apt/Lot #) (City) (Zip) (County)

MAILING ADDRESS: (If different): ____
(P. O. Box #) (City) (Zip) (County)

4

FATHER'S NAME:____
FIRST, MIDDLE, LAST

DATE OF BIRTH: ______________________________

RACIAL/ETHNIC BACKGROUND (Check **ALL** that apply): ☐ **White** ☐ **Black/African American** ☐ **Asian** ☐ **American Indian/Alaska Native** ☐ **Native Hawaiian/Other Pacific Islander** ☐ **Other:** ____________ **Hispanic/Latino? (Y / N)**

PRIMARY LANGUAGE: ☐ **English** ☐ **Spanish** ☐ **American Sign Language** ☐ **Other:** ____________

ENGLISH SPEAKING ABILITY: ☐ **Very Well** ☐ **Well** ☐ **Not Well** ☐ **Not At All**

PRIMARY PHONE: ____________________**(H/C/W) OPT in for text messages (Y / N)**

SECONDARY PHONE: ____________________**(H/C/W) E-MAIL ADDRESS:** ____________________

EDUCATION: (please write highest grade completed) ____________

WORK HISTORY: Is he working? (Y / N) ☐ Part Time ☐ Full Time (35 hr +) ☐ Other ____________

5

MARITAL STATUS OF BIRTH PARENT(S): ☐ Married/Living Together ☐ Legally Married/Not Living Together ☐ Divorced ☐ Widowed ☐ Never Married/Living Together ☐ Never Married/Not Living Together

6

WHAT IS YOUR CURRENT LIVING ARRANGEMENT? ☐ Rent ☐ Own ☐ Relative/Friend provides a stable home

I AM HOMELESS: ☐ Yes ☐ No *This means that you and/or your family is staying in a car, park, campground, hotel, emergency shelter, transitional housing, or your family is temporarily living with another family member or friend*

***IF HOMELESS PLEASE CHECK WHICH APPLIES:**

☐ Motel/Hotel ☐ Shelter ☐ Mission/Church ☐ Transitional Housing ☐ Staying with family/friends (temporary)

7

PERSON IN THE HOME, (OTHER THAN PARENT/GUARDIAN), AGE 18 OR OLDER TO CONTACT:
(For example a legal step-parent, grandparent, girlfriend/boyfriend, partner)

____
(First) (Last) (Relationship to mom) (Phone) (Date of Birth)

8

ADDITONAL CONTACT PERSON(S) IF WE ARE UNABLE TO REACH YOU:

1.____
(First) (Last) (Relationship to mom) (Phone) (Date of Birth)

2.____
(First) (Last) (Relationship to mom) (Phone) (Date of Birth)

9	**List The Names of All Siblings To The Unborn Child In The Household:** (First) (Last) (Relationship to the unborn child) 1.________________________ ☐Male ☐Female Date of Birth __________ 2.________________________ ☐Male ☐Female Date of Birth __________ 3.________________________ ☐Male ☐Female Date of Birth __________ 4.________________________ ☐Male ☐Female Date of Birth __________ 5.________________________ ☐Male ☐Female Date of Birth __________
10	**DO YOU HAVE ANY FAMILY CONCERNS?** ☐Yes ☐No **If yes, please check All that apply:** ☐Reading ☐Writing ☐Parent has IEP ☐Ongoing Education ☐Transportation ☐Physical Health ☐Mental Health ☐Food ☐Shelter ☐Unemployed/Not enough hours ☐Violence ☐Alcohol/Drug use ☐Legal Concerns ☐A Parent/Guardian is Incarcerated ☐Other/Explain: ________________
11	**HAVE YOU BEEN PROFESSIONALLY REFERRED?** ☐Yes ☐No (Check **ALL** that apply): ☐Day Care ☐Job Center: La Crosse County ☐Counselor ☐Public School Staff ☐Birth-3 ☐Family Resource Center ☐Community Health Program/WIC ☐Doctor ☐Early Head Start/Head Start ☐Health & Human Services ☐Teen-Parent Connections ☐Homeless shelter/Domestic violence shelter ☐Other:__________________ ☐**If nothing above how did you find out about us?** ________________
12	**DOES ANY MEMBER OF THE HOUSEHOLD RECEIVE THE FOLLOWING?** ☐Yes ☐No (Check **ALL** that apply): ☐Kinship Care ☐Food Stamps ☐Unemployment ☐Health Insurance ☐WIC/Healthy Start ☐Public Assistance/W2 ☐SSI-Supplemental Security Income ☐SSDI-Social Security Disability Income ☐Survivors Benefits ☐Caretaker Supplement ☐Public Housing/Section 8 ☐Energy Assistance ☐Child Care Assistance ☐Child Support/Received ☐Foster Care/Adoption Subsidy ☐Other Income: _______________ ☐None of the above
13	**INCOME VERIFICATION:** Family income is the income of the biological parent(s) /adoptive parent(s) or guardian(s) living in the household. ****PROOF OF INCOME SHOULD BE RETURNED WITH THE APPLICATION**** **A) TYPES OF INCOME:** (1) Pay stubs for both working adults (2) Most recent filed Taxes or W-2 (3) Unemployment (4) Written statement from employer (5) Cash payments (No Income Form) (6) Child Support Payments (childsupport.wisconsin.gov or 800-991-5530) ***If none of these apply go to letter B*** **B) OTHER INCOME:** (1) Current SSI Award Letter (2) Current TANF (Public Assistance from the County) (3) Current Kinship Care (4) Current Foster Care Payment *For children receiving Kinship Care/Foster Care, send only the amount you receive for the child's care* *Contact the enrollment office if none of these types of income apply to you.* ****PLEASE DO NOT SEND ORIGINALS****
14	****PLEASE READ STATEMENTS BELOW CAREFULLY BEFORE SIGNING**** By signing, I verify that I am the parent/legal guardian of this child and that the information provided is correct and complete to the best of my knowledge. I further understand that if I knowingly provide false information that my family may no longer be eligible for further services. SIGN AND DATE: (WHEN BOTH PARENTS LIVE IN THE HOME THEN BOTH SHOULD SIGN IF POSSIBLE) Parent/Guardian Signature: ______________________ Date: ______________ Parent/Guardian Signature: ______________________ Date: ______________ **PLEASE PROVIDE WRITTEN INFORMATION IN** ☐ENGLISH ☐SPANISH ****REMEMBER…AN INCOMPLETE APPLICATION WILL DELAY PROCESSING ***

Head Start Child and Family Development Centers, Inc.
333 Buchner Place, La Crosse, WI 54603 · **Phone**: 608-785-2070 · **Fax:** 608-785-2079

Pregnancy Health History and Nutrition Screening

Name: ____ **Date:** ___________________________ **cc:** ________________

Primary Care Physician: ____ Clinic: ____________________________________

Prenatal Care Physician: ____ Clinic: ____________________________________

Dentist: ____ Clinic: ____________________________________

Insurance:

☐ None ☐ Badger Care/HMO: _________________________ ☐ Private/HMO: ______________________________

Due Date: ___________________ Date of last prenatal exam: ____ /____ / ____ Date of last dental exam ____ /____ / ____

How many pregnancies have you had prior to this one? __________ Date of last pregnancy: __________________________

Number of children/ages: _________ / ______________ Have you ever experienced a high risk pregnancy? ☐ Yes ☐ No

Type of Complication	Dates of pregnancy	Bed rest needed? # of days needed?	Baby born at due date or premature?	Baby weighed?
1.				
2.				
3.				
4.				

Has your Doctor shared concerns that this could be a high-risk pregnancy? ☐ Yes ☐ No

Are you currently taking prenatal vitamins? ☐ Yes ☐ No Are they prescribed by your Doctor? ☐ Yes ☐ No

Names of prescription medications currently taking	Names of over the counter medications currently taking
1.	1.
2.	2.
3.	3.
4.	4.

	What?	How much/ how often?	When?
Are you currently smoking?			
Are you currently drinking beer, wine, or hard liquor?			
Are you being exposed to 2nd hand smoke?			
Have you or are you using recreational or street drugs?			

Do you have allergies? ☐ Yes ☐ No Allergies to: ____

Have you, or are you experiencing any of the following health concerns?

	History of:		Currently:	
Asthma	☐ Yes	☐ No	☐ Yes	☐ No
Ulcers or other stomach problems	☐ Yes	☐ No	☐ Yes	☐ No
Diabetes?	☐ Yes	☐ No	☐ Yes	☐ No
Heart Problems?	☐ Yes	☐ No	☐ Yes	☐ No
High Blood Pressure?	☐ Yes	☐ No	☐ Yes	☐ No
Seizures?	☐ Yes	☐ No	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No	☐ Yes	☐ No
Sexually transmitted disease	☐ Yes	☐ No	☐ Yes	☐ No
Other? _________________________	☐ Yes	☐ No	☐ Yes	☐ No

How many servings do you eat from the following food groups each day?

Food Group	No	Yes	If yes, # of servings each day
Milk, Yogurt, & Cheese Group			
Vegetable Group			
Fruit Group			
Meat, Poultry, Fish, Dry Beans, Eggs, & Nuts Group			
Bread, Cereal, Rice, and Pasta Group			
Fats, Oils, and Sweets			
Water ☐ City Water ☐ Well Water			

My favorite food is: ___________________________________

Are you currently participating in WIC? ___________ Do you plan to breastfeed? ☐ Yes ☐ No

Have you breastfed before? ☐ Yes ☐ No Did you have trouble or concerns? ☐ Yes ☐ No

If yes, what were your concerns? ____

Would you like information about or support with breastfeeding? ☐ Yes ☐ No

What did you weigh prior to pregnancy? _____________ Height: _____________ Current Weight: _____________

Are you concerned about your weight? ☐ Yes ☐ No If yes, why? ____

How is your appetite? ____

How often do you eat during the day? __________ Times. Is this typical? ☐ Yes ☐ No

Are you avoiding or has your Doctor recommended you avoid any foods? ☐ Yes ☐ No If yes, what foods? ___________

Have you, or have you had the desire to eat non-food items like clay, dirt, ice? ☐ Yes ☐ No

Have you discussed physical activity with your Doctor? ☐ Yes ☐ No

What physical activity do you currently do? ____

Participant Signature: ____ Date: ________________________